

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF COPPER BASIN			STREET ADDRESS, CITY, STATE, ZIP CODE 166 COPPER BASIN INDUSTRIAL PARK PO BOX 518 DUCKTOWN, TN 37326		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments During the annual Licensure survey and complaint investigation #29891, conducted on August 20-22, 2012, at Life Care Center of Copper Basin, no deficiencies were cited in relation to the complaint under 1200-8-6 Standards for Nursing Homes.	N 000			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

Administrator

(X6) DATE

9/5/12

6899

UC9J11

If continuation sheet 1 of 1

SEP 06 2012